Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FREEWAY SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box
44

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Date Received
MARCH 21, 2005

MFDR Tracking Number
M4-05-5512-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 17, 2005: "This injured employee had surgery and was treated at Memorial Hermann from March 23, 2004 through April 1, 2004. The patient remained hospitalized for a period of 9 days recouping from surgery and his severe infection. The hospital billed its usual and customary charges in the total amount of $24,552.75. The admission was authorized by the claimant's employer. The carrier should have applied the surgical per diem reimbursement model and paid $10,062.00 (9 days at $1,118.00); fair and reasonable MRI charges of $1,673.00 plus an additional $253.37 for the implants (cost plus 10%), for a total payment of $11,998.37. The carrier only paid a total of $450.80 without benefit of explanation. This claim is underpaid in the total amount of $11,537.57."

Amount in Dispute: $11,537.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Received in MDR on March 29, 2005: The respondent's response did not include a position summary.

Response Submitted by: Gallagher Bassett, 16414 San Pedro, #400, San Antonio, TX 78232

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
March 23, 2004 Through April 1, 2004	Inpatient Hospital Services	$11,537.57	$9,864.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to

requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated June 15, 2004
- C – Negotiated contract price

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code, "C – Negotiated contract price". Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(1) states "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401(c)(2)(A) states "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical or surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401(c)(3)(A)(i and ii) states "Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem amount (SPDA) is multiplied by the length of stay (LOS) for admission." 28 Texas Administrative Code §134.401(c)(4)(A)(i and ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%...(i) Implantables (revenue codes 275, 276, and 278) , and (ii) Orthotics and prosthetics (revenue code 274)." 28 Texas Administrative Code §134.401(c)(4)(B)(i - iv) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)."

3. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was nine days. The surgical per diem rate of $1,118 multiplied by the length of stay of nine days results in an allowable amount of $10,062.00.

   The division notes that 28 Texas Administrative Code §134.401(c)(4)(B)(ii) states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)." Review of the medical bills finds that the requestor billed $1,673.00 for an MRI under revenue code 610. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 610 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

   The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically

necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that the following item was billed under revenue code 0278 and is therefore eligible for separate payment under §134.401(c)(4)(A) as follows:

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS	Total Cost from Invoice	Cost + 10%
0278	CORTICAL CANCELLOUS STRUTS	CORT/ CANC STRUTS	2 at $115.17 EACH	$230.34	$253.37
			TOTAL ALLOWABLE *$253.37*		

The division concludes that the total allowable for this admission is $10,062.00 + $253.37 = $10,315.37. The respondent issued payment in the amount of $450.80. Based upon the documentation submitted, additional reimbursement in the amount of $9,864.57 is recommended.

Conclusion

The submitted documentation does support additional reimbursement is due. As a result, additional reimbursement in the amount of $9,864.57 is recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $9,864.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		September 17, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		September 17, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.